STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a revisit survey combined with an annual re-certification survey which was conducted at your facility in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities, from 6/22/09 through 6/26/09. The revisit was in response to the findings of a previous complaint survey conducted on 4/21/09. The census on 6/22/09 was 120 residents. The sample size was 24 sampled residents which included 3 closed records. An Immediate Jeopardy situation was identified on 6/24/09 at 2:30 PM, at CFR 483.10(b)(11) Notification of Change (F Tag 157). The Immediate Jeopardy was abated at 4:15 PM on 6/24/09. The findings of the survey found the facility still out of compliance with F Tags 157 and 441. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	{F 000}		
{F 157} SS=J	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician	{F 157}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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{F 157}	Continued From page 1 intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, facility procedures, and interview, the facility failed to ensure that changes in condition were properly identified, staff and physicians were consistently informed of residents' changes in condition, and interventions were initiated and communicated for 3 of 24 residents (Residents #8, #9, #23) and failed to establish protocols to ensure consulting physicians were informed whether their recommendations of interventions for changes in condition were accepted or declined for 1 of 24	{F 157}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

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HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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{F 157}	Continued From page 2	{F 157}		

residents (Resident #5).

Findings include:

1. Resident #5

Resident #5 was admitted to the facility on 8/23/03. Her diagnoses included Alzheimer's Disease, chronic obstructive pulmonary disease, and a neoplasm of the lung.

An Endocrinologist's note dated 12/12/08, revealed the physician declared that Resident #5's ultrasound disclosed a 2.5 cm right nodule of the thyroid. The physician further noted she tried for over two years to obtain thyroid functions for the resident, the correct labs were not drawn, and Resident #5 had a dangerously large nodule that could be cancer. In conclusion, the physician stated she could no longer follow the resident with "the total noncompliance by her caregivers."

The resident had been seen by the facility's nurse practioner the latter part of 2006 and based on the results of some basic thyroid tests, a referral was made to the specialist. An appointment was not obtained until 4/16/07. The specialist's progress note indicated thyroid functions, antibodies, thyroglobulin, basic metabolic panel and a thyroid ultrasound would be obtained. The specialist referenced the lab slips were sent back to the facility with the resident. The nurse's notes for the facility and a progress document confirmed the ultrasound was performed on 5/03/07. There was no evidence of laboratory studies ever being obtained.

An additional laboratory test request form from the specialist was present in the record indicating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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{F 157}	Continued From page 3	{F 157}		

the following tests needed to be drawn 5-7 days before an appointment scheduled for 6/20/08; basic metabolic panel, CBC, TSH, free T4 Hormone, T3 Hormone, thyroglobulin, antithyroglobulin and antibodies. There was no evidence that the laboratory tests were obtained by the facility.

On the next appointment on 12/12/08 when the requested lab studies were again not available, the physician refused to follow the resident any longer.

On 6/23/09 at 12:15 PM, an interview was conducted with the Director of Nurses (DON). When asked what she knew about the situation, the DON stated, "the charge nurse on the resident's unit had taken care of it and it was all cleared up."

At 12:15 PM, an interview was conducted with Charge Nurse (Employee #18). She stated that she had taken care of the lab slips and everything was all right. When asked when she had taken care of it, she declared that she didn't remember the date. She was unable to produce any documentation that the requested labs had been drawn, that the resident's facility physician had been notified of the situation, or that any follow-up care had been sought for the resident's potentially dangerous medical condition.

An interview was conducted with the transportation coordinator at 2:00 PM, who confirmed that Resident #5 had not been seen by the Endocrinologist since 12/12/08 when the transportation coordinator was told by the office staff that the specialist would not see the resident again.

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	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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{F 157}	Continued From page 4 An immediate jeopardy was identified to the administrative staff on 6/24/09 at 2:30 PM. The administrative staff identified some immediate actions on 6/24/09, which included immediately drawing the previously mentioned laboratory tests and obtaining an appointment for the following week with another Endocrinologist. A written plan of action was developed and presented on 6/24/09. The plan included a more inclusive facility-wide policy. A 24 hour chart check was implemented in which the night shift was to review all new lab orders. All lab orders were to be placed on the 24 hour report board and also in the lab book. When the labs were drawn, they were to be initialed in the lab book and noted on the 24 hour board. They were to be kept on the 24 hour report and the lab book until the results were received and noted by the physician. All results of tests ordered by outside physicians were to be faxed to the individual offices and a fax transmittal along with a copy of the lab results would be sent with the resident on the day of the follow up visit. All lab orders, 24 hour report and the lab book will be reviewed at morning Stand Up Meeting by the Interdisciplinary Team. The Transportation Department was instructed that they were to copy any documentation from a resident's appointment and give it to the Administrator and give the original to the Charge Nurse. Staff were instructed at the next morning's Stand Up Meeting to ensure that a proper follow-up would take place. The immediate jeopardy was abated 4:10 PM on 6/24/09. Prior to 6/26/09, none of the abatement procedures were in place. It was difficult to track	{F 157}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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{F 157}	Continued From page 5	{F 157}		

why Resident #5's outside recommendations were not followed. If the facility's physician or physician's assistant did not agree with the outside physicians' recommendation or chose not to pursue the plan for whatever reason, there was a failure on the part of the facility's medical staff to document justifications. There was a failure of the facility's nursing staff to follow-up on the lack of response to recommendations for the resident and document their findings.

An interview with the Medical Director at 11:30 AM on 6/26/09, revealed there was no set practice to inform consultants that their recommendations were not going to be acted on or the rationale why not. The Medical Director acknowledged that residents were sent to consultants for recommendations, but that if he or other primary physicians felt the recommendations were not advised, they would not follow them. He also acknowledged that the consulting physician would not be contacted regarding the primary physician's decision. He did acknowledge that the primary physician should document the rationale why the recommendations were not followed.

Regarding Resident #5, the Medical Director confirmed he was her primary physician. He confirmed that he signed the recommendations of the consultant, to acknowledge that he had seen them, but he did not document any information why he was not going to follow the recommendations. The Medical Director stated, "I dropped the ball on (Resident #5). I should have written why I wasn't going to follow the recommendation. I shouldn't have sent her to the consultant."

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	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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{F 157}	Continued From page 6	{F 157}		

2. An interview on 6/22/09, with the Director of Nursing (DON) and the Administrator confirmed the facility instituted a change in condition form to be completed by the charge nurses of each wing, each shift. This became effective 5/22/09. This form was to enable residents who were having changes in condition to be identified and monitored. Infections, elevated temperatures, injuries, and weight loss, were examples of what could be a change in condition.

Resident #9

Resident # 9 was an 80 year old female, admitted to the agency on 6/10/09, following an acute care hospitalization for endocarditis. Her other diagnoses included lymphoma of the colon, lung, and received resection of these tumors and radiation approximately two years ago. The history and physical from the hospital also related a recent two week history of extreme fatigue and nausea, and lack of appetite because of resulting vomiting.

Resident #9's weight on admission was 106. The weight record revealed a loss of approximately one pound a day until 6/17/09, when Resident #9 weighed 100 pounds. The nutritional assessment performed by the dietician on 6/11/09, identified that Resident #9's ideal body weight should be approximately 135 pounds which was her stated weight six months ago. The dietician recognized Resident #9 complained of gum pain with her dentures, but did not want any change in consistency for her diet to assist in chewing.

There was no further evidence that Resident #9 was monitored for continuing weight loss or other interventions initiated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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{F 157}	Continued From page 7	{F 157}		

On 6/22/09, the DON confirmed the weight committee identified Resident #9's ongoing weight loss and the recommendations were written and given to the charge nurse of that wing. The DON also confirmed the various committees did not add their recommendations to the care plans themselves. The recommendations were given to various charge nurses.

An interview with Employee #11 confirmed the various committees left recommendations with the various charge nurses, but the charge nurses often did not have the time to enter the recommendations into the plan of care. The care plan revealed no added recommendations.

The change in condition for June revealed no mention of Resident #9's weight loss. There was no evidence the physician was aware of the weight loss.

Resident #8

Resident #8 was a 62 year old female who was admitted to the facility on 4/29/09, following an acute care hospitalization 3/19/09-4/28/09. Her admitting diagnoses included osteomyelitis, diabetes, chronic obstructive pulmonary disease. A discharge summary from the hospital dated 4/28/09, indicated Patient #8 had a non-healing polymicrobial wound on her left heel containing the following Methicillin resistant staph (MRSA), enterococcus, coagulase negative staph and diphtheroids.

A dietary assessment on 5/28/09 revealed Resident #8's weight loss was unavoidable due to Sarcopenia (a degenerative loss of skeletal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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{F 157}	Continued From page 8	{F 157}		

muscle mass and strength), increased tumor necrosis factor, leukotriesis (inflammatory response of the body), chronic osteomyelitis, and not responding to treatment.

Review of the care plans, wound assessment sheets and nursing notes revealed that Resident #8 had refused meals and that her wounds were deteriorating. The physician was aware and had written orders for full liquid diet and force fluids.

Nurse's notes revealed that the wound care had been changed (acetic acid and dry dressing to the left heel; coccyx wound changed to packing the wound with "fluffs" to accommodate the increased dressing). There was no documentation in the change in condition reports that the changes had occurred.

There was no evidence in the change in condition reports that interventions were instituted, such as, increasing fluids, pain control, comfort measures or their effectiveness, or that the wound on the coccyx became a stage four and continued to decline in condition. There was no consistent documentation of Resident #8's progressive decline. Resident #8 was transferred to an acute care facility on 6/22/09, due to her deteriorated condition.

Resident #23

Resident #23 was admitted to the facility on 6/9/09, following a fall and requiring surgical repair of her left lower leg (tibia) and placement of an external fixator to secure the surgical repair. She was confined to a wheelchair and was ordered non-weight bearing on the left leg. Resident #23 had approximately six insertion

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 157}	Continued From page 9 sites to her left leg where the external fixator was secured through the skin to the bone. On 6/17/09, the physician documented Resident #23 expressed concern that her left foot might be infected. Lab work was ordered to rule out infection. This was done 6/10/09, but was not documented on the change in condition report. On 6/23/09, the physician ordered an oral antibiotic for erythema and Ibuprofen for significant pain of the left foot. The change in condition sheet identified Keflex was ordered for left foot infection but did not address the pain. The change in condition forms dated 6/23-25/09, revealed the "left foot infection" had been changed to "wound infection." An interview with two licensed staff members, Employee #13 and #14, both acknowledged that they thought the antibiotics were for the left leg external fixator pin sites, not a possible infection of the left foot. They both confirmed there was no documentation in the clinical record to demonstrate either the pin sites or the left foot were being monitored every shift for pain or signs of infection. On 6/23/09 Resident #23, with Employee #13 present, expressed concern to the primary physician because her left foot at the heel was extremely painful and the foot/heel area was red. Employee #13 acknowledged he had not been aware of these symptoms, and thought the suspected infection was at the pin sites.	{F 157}		
{F 441} SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 10 to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to establish and maintain infection control measures designed to prevent the transmission of disease and infection and failed to control the possible spread of an infectious process by placing 2 residents in rooms where the other resident was on contact isolation (Residents #9, 17), by allowing a resident access to common ice chests without proper equipment (Resident #14) and by not taking adequate precautions with biohazard equipment. Findings include: 1. On 6/22/09 at 12:45 PM at the 100 wing, Resident #14 was observed walking into an unlocked medical supply room. The room contained a large ice chest and nutritional supplements. As she came out of the room, the resident was asked why she had gone into the room. The resident responded, "I ask them to bring ice, but only one nurse brings ice. They say, 'I'm busy.' I need ice twice a day because my mouth gets dry." When asked if she used the scoop attached to the ice chest, she said, "No, I use my pitcher."	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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{F 441}	Continued From page 11 A certified nursing assistant (CNA) working on the 100 wing, Employee #8, was asked if residents were supposed to go into the medical supply room. The CNA responded, "Only staff were allowed in that room." The CNA also acknowledged that the ice chest was used to refill all the residents' water pitchers with ice on that side of the facility. 2. Resident #17 Resident #17 was re-admitted to the facility on 6/2/09, after an acute hospital stay of 3 days, with diagnoses of vascular dementia, Type II diabetes, hypertension and bipolar. During the survey, the resident was observed on contact isolation. Indications for the isolation was the presence of Methicillin resistant staph (MRSA) in the resident's urine. The isolation was in effect since 6/4/09. The resident was treated with several courses of antibiotics. The most recent course was ordered on 6/23/09. The other resident in Resident #17's room did not have MRSA or any other infectious process. The other resident had just experienced a severe episode of Herpes Zoster, had been on a course of Acyclovir and had frequent skin tears. The facility's policy on Infection Control, Subject: MRSA stated under Patient/Resident Placement that "it is preferred that patients/residents with MRSA not share a room with immunocompromised patients/residents, with wounds or with invasive devices." Resident #9	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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{F 441}	Continued From page 12 Resident #9 was admitted to the facility following an acute care hospitalization for endocarditis, and a urinary tract infection with Methicillin resistant staph (MRSA) infection on 6/10/09. Resident #9 received intravenous administration of Vancomycin every 48 hours. She was placed in a semi-private room on contact isolation. During the initial tour on 6/22/09, it was revealed Resident #9's roommate was also admitted from an acute care hospitalization for rehabilitation therapy following back surgery. Both residents were ambulatory, and shared the bathroom. The licensed practical nurse (LPN) (Employee #11) on 6/22/09, revealed she questioned the placement of the two residents in the same room. Employee #11 was aware of the risk MRSA transmission from one resident to the other. Both residents were ambulatory and sharing the same bathroom presented a risk of MRSA transmission to the other resident. Patient #9 was to use the bedside commode, but the excrement would then be dumped in the bathroom toilet. Two CNAs were interviewed regarding infection control processes used to clean the bathroom toilet after dumping waste from the bedside commode. There was no consistency in the procedures the CNAs followed. One used Clorox wipes located on the isolation cart. The second CNA used a germicidal cleanser used in the shower room to clean the shower chair between residents. Neither of the items were located in the bathroom shared by the two residents. On 6/23/09, the bedside commode was observed placed in the bathroom. An interview with	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 13	{F 441}		

Resident #9 revealed she had moved the bedside commode into the bathroom to provide privacy when she used it. The bedside commode remained in the bathroom for approximately one hour after the initial observation until staff were asked about it. The bedside commode was subsequently replaced at Resident #9's bedside.

3. On 6/23/09 at 1:10 PM, observation revealed a centrifuge located at the nurse's station on B pod. There was a bio-hazard sticker on the centrifuge. No staff member was present and the machine was operating. No personal protective equipment, such a gloves, mask or blood spill kits were visible. This observation continued for approximately 15 minutes until the machine stopped operating without any staff member present. Two Vacutainers were visible in the machine through the clear cover.

A second observation at approximately 2:00 PM on 6/24/09 occurred at the B pod nurse's station. The Director of Nursing (DON) was observed placing a Vacutainer containing a blood specimen into the centrifuge without the use of disposable gloves. A unit secretary was sitting next to the area of the centrifuge's location. The DON started the machine and left. A ward secretary was asked if any personal protective equipment or a blood spill kit was located near the B pod centrifuge. The ward secretary had gloves at her work area, but searched through three drawers before she found the blood spill kit. The drawer was not labeled as containing the blood spill kit. The ward secretary confirmed she was not aware that blood specimen tubes could break or explode during the centrifuge process. The centrifuge was not visible from the outer side of the desk due to a raised counter The secretary confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	R-C 06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 14 staff and residents would approach her desk, look over the counter, and place their faces and upper body directly over the centrifuge without realizing the risk. The ward secretary revealed the lab delivered two centrifuges to process blood specimens. The other centrifuge was located on A pod, in the bio-hazard room. The secretary did not know why the centrifuge on B pod was not in the B pod's bio-hazard room. She went into the bio-hazard room and determined there was space and electrical access for the centrifuge. Both the infection control nurse and the ward secretary acknowledged re-locating the centrifuge to the bio-hazard room was more appropriate.	{F 441}		